HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 881 CS Community Behavioral Health Agencies
SPONSOR(S): Cannon and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2486

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance Committee	19 Y, 0 N, w/CS	Cooper	Cooper
2) Civil Justice Committee			
3) Health Care Appropriations Committee			
4) Commerce Council			
5)			

SUMMARY ANALYSIS

Pursuant to 624.462, F.S., a not-for-profit trade association, industry association, or professional association of employers or professionals which has been organized for purposes other than that of obtaining or providing insurance may form a commercial self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any commercial property or casualty risk or surety insurance.

This bill provides that, notwithstanding any other provision of law, mental health or substance abuse providers which are members in good standing of a nonprofit statewide association which has been in existence for at least 10 years and is comprised of at least 50 community-based mental health and substance abuse agencies which are primarily publicly funded and located in this state may form a self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any property or casualty risk or surety insurance or securing the payment of benefits under worker's compensation. This authorization is predicated upon the fund: 1) having annual normal premiums in excess of $5 million; 2) maintaining a continuing program of excess insurance coverage and reserve evaluation to protect the fund's financial stability; 3) submitting to the Office of Insurance Regulation annual audited financial statements; and 4) having a governing body comprised entirely of provider officials. For a fund's first 5 years of its existence the fund must comply with the same regulatory requirements of all other commercial or group self-insurance funds.

The bill also exempts the self insurance fund from the solvency, reserve and financial reporting requirements pertaining to workers compensation group self insurance funds, as well as from the premium tax and participation in the Florida Self-Insurance Fund Guaranty Association after five years of a fund's formation.

At common law, the state was immune from lawsuits under the doctrine of sovereign immunity. Article X, section 13, Fla. Const., permits the state to waive sovereign immunity and permit lawsuits by general law. Florida's waiver of sovereign immunity permits certain lawsuits, but it imposes monetary limits on recovery - $100,000 per claimant and $200,000 per incident. Judgments or settlements in excess of those caps can be recovered by the passage of a claims bill in the Legislature.

The bill designates certain substance abuse treatment and mental health service providers as agents of the state for the purposes of the sovereign immunity statute. It grants immunity pursuant to contractual arrangements between providers and the Department of Children and Families (DCF). However the immunity only applies to publicly funded services. The bill also states that the contract must provide for the indemnification of the state by the agent for any liabilities incurred up to the limits set out in law and that a person who provides contracted services to DCF is not an employee or agent of the state for purposes of workers' compensation.

The bill's provisions exempting self-insurance funds from the premium tax and relating to sovereign immunity will have an undetermined fiscal impact.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – The bill exempts certain providers of mental health and substance abuse services from the statutory requirements of forming self-insurance funds. The bill also makes providers of those services agents of the state for the purpose of limiting their legal liability.

Ensure lower taxes – The bill exempts specifically authorized self-insurance funds from the premium tax. Making providers agents of the state may impact the state's financial resources.

Safeguard individual liberty – The bill reduces regulatory oversight over programs to compensate injured employees (workers compensation) and patients (tort). The bill limits the amount of damages an injured plaintiff may recover.

Promote personal responsibility – The bill will place more responsibility for ensuring financial accountability and solvency on the providers who participate in the self-insurance fund authorized by this bill. Also, the bill limits the liability of a provider who injures a patient. Recovery for amounts above the limits specified in the sovereign immunity statute, if approved by the Legislature in a claims bill, will originate from the state budget.

Empower families – To the extent that providers reduce their costs for liability insurance and from legal immunity, the offering of services, with the attendant emotional and financial benefits, may increase for families. To the extent that injured patients are not able to recover fully for their injuries then more families may be dependent on Medicaid or other governmental assistance programs.

B. EFFECT OF PROPOSED CHANGES:

Self-Insurance Funds

Current Law Regarding Self-Insurance Funds

Section 624.460-624.488 is known as the "Commercial Self-Insurance Fund Act." Self-insurance fund means both commercial insurance funds organized under s.624.462 and group self-insurance funds organized under s.624.4621.

Pursuant to 624.462, F.S., a not-for-profit trade association, industry association, or professional association of employers or professionals which has been organized for purposes other than that of obtaining or providing insurance may form a commercial self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any commercial property or casualty risk or surety insurance.

An entity that forms a self-insurance fund under current law must obtain and maintain a certificate of authority. Among the initial and continuing regulatory requirements necessary for a certificate of authority are measures relating to plans of risk management, certain financial statements of members, excess insurance, surplus and reserve requirements, assurances of actuarial soundness and assessment procedures. Under current law a commercial self insurance fund is also subject to the premium tax, form and rate approval, and regulatory oversight regarding rehabilitation, liquidation, reorganization and conservation, and is required to participate in the Florida Group Self-Insurers Guaranty Association.

Pursuant to s. 624.4621, F.S., two or more employers are allowed to pool their workers' compensation liabilities and form a self insurance fund for workers' compensation purposes. If employers elect to become a self insurance fund for workers' compensation purposes, the fund must comply with administrative rules adopted by the Financial Services Commission relating to reserve requirements, organization, and operation. The rules relating to reserve requirements are designed to insure the self-insurance fund can maintain financial

solvency. Current law also requires workers' compensation self insurance funds to carry reinsurance, unless the fund is comprised of state or local government employers.[1] Current law establishes restrictions on dividend or premium refunds made by a workers' compensation self insurance fund.[2] Workers' compensation self-insurance funds are subject to the insurance premium tax, but at a reduced rate. The rate is reduced from 1.75 percent of the gross receipt of insurance premiums to 1.6 percent.[3] Workers' compensation self-insurance funds are subject to license taxes and premium receipt taxes.[4] Current law also requires workers' compensation self insurance funds to participate in the Florida Self-Insurance Fund Guaranty Association (Association).[5] The purpose of the Association is to pay workers' compensation claims of self-insurance funds that may become insolvent.[6]

In addition to complying with the administrative rules for workers' compensation self-insurance established by the Financial Services Commission, a workers' compensation self-insurance fund must comply with administrative rules adopted by the Department of Financial Services (DFS) relating to the filing of reports by workers' compensation self-insurance funds.[7]

The Commercial Self-Insurance Fund Act also contains a provision which makes over 228 sections of the Florida Insurance Code applicable to the self-insurance funds.[8] Among those many provisions are laws relating to civil remedy and civil liability; accounting, assets and liabilities investments, administration of deposits, insurance field representatives and operations; unfair methods of competition and unfair or deceptive acts or practices; powers of department and office; cease and desist procedures and penalties; policyholders bill of rights claims administration; payment of settlements; attorney's fees; insurance rates and contracts; motor vehicle and casualty contracts; professional liability claims and actions; reports by insurers and health care providers; and, as previously indicated, provisions relating to insurer insolvency; rehabilitation and liquidation; and the Florida Self-Insurance Fund Guaranty Association.

Florida Council for Community Mental Health and the Florida Council for Behavioral Healthcare

The Florida Council for Community Mental Health (FCCMH or Council), a 501(c)(3) corporation, and its sister organization, the Florida Council for Behavioral Healthcare – a 501(c)(6) corporation established for political action purposes, are statewide associations of 70 community-based mental health and substance abuse agencies. FCCMH was formed in 1958 as an association of mental health clinic directors. Its role broadened in the 1960s and 1970s, as the focus of treatment shifted from state hospitals to communities. The association's membership expanded to include a number of agencies that specialize in substance abuse services and children's services. [9]

The Council is the sole community mental health provider association and the largest behavioral health association representing local mental health interests in Florida. Council members serve predominately low-income individuals and families and the majority of the adults and children receiving publicly-funded mental health and substance abuse services in Florida. Most clients served by member agencies are adults with serious and persistent mental illness, children with severe emotional disturbance, adults with long-term addictions, and children who are drug users or at risk of abusing drugs. Member agencies provide a range of services, including emergency services, residential treatment, crisis stabilization, outpatient services and rehabilitation and support services.

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[1] s. 624.4621(4), F.S. (2004).
[2] s. 624.4621(5), F.S. (2004).
[3] s. 624.4621(7), F.S. (2004); s. 624.509(1), F.S. (2004).
[4] s. 624.509(2), F.S. (2004).
[5] s. 624.4621(9), F.S. (2004).
[6] s. 440.385(3)(a), F.S. (2004).
[7] s. 440.38(2)(b), F.S. (2004); *See* Chapter 4L-5, F.A.C. for the administrative rules relating to workers' compensation self-insurance funds.
[8] s. 624.488, F.S. (2004)
[9] Email from Bob Sharpe, President and CEO of FCCMH, March 9, 2005 on file with the Insurance Committee.

Member agencies provide behavioral health care for Medicaid, Medicare, Department of Children and Families and commercially insured populations. According to the Council they serve as the state's public behavioral health safety net.

Proposed Changes Regarding Self-insurance Funds

This bill provides that, notwithstanding any other provision of law, mental health or substance abuse providers which are members of the Florida Council for Community Mental Health or the Florida Council for Behavioral Healthcare may form a self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any property or casualty risk or surety insurance or securing the payment of benefits under worker's compensation. This authorization is predicated upon the fund: 1) having annual normal premiums in excess of $5 million; 2) maintaining a continuing program of excess insurance coverage and reserve evaluation to protect the fund's financial stability; 3) submitting to the Office of Insurance Regulation annual audited financial statements; and 4) having a governing body comprised entirely of provider officials. For a fund's first 5 years of its existence the fund must comply with the same regulatory requirements of all other commercial or group self-insurance funds.

After 5 years, the bill exempts self insurance funds composed of two or more nonprofit community mental health and substance abuse providers from the provisions in current law applicable to workers' compensation self-insurance funds relating to reserve requirements, reinsurance requirements, restrictions on dividend or premium refunds, and mandatory participation in the Florida Self-Insurance Fund Guaranty Association. The bill exempts these self-insurance funds from the premium tax, license tax, and premium receipt tax. The bill also exempts these self-insurance funds from the rules promulgated by DFS relating to reports workers' compensation self-insurance funds must file with DFS.

The bill revokes the exemptions from the statutory requirements relating to reserve requirements, reinsurance requirements, restrictions on dividend or premium refunds, mandatory participation in the Florida Self-Insurance Fund Guaranty Association, and taxes if the community mental health and substance abuse provider self-insurance fund does not have annual normal premiums in excess of $5 million, does not maintain a continuing program of excess insurance coverage and reserve evaluation, and does not annually submit an audited fiscal year end financial statement to the Office of Insurance Regulation.

According to FCCMH, availability of property, liability, automobile and workers' compensation insurance is limited for its members and members of its sister organization, the Florida Council for Behavioral Healthcare (FCBH). The Council maintains that its 70 member treatment organizations are a critical part of the state's safety net, providing publicly funded mental health and substance abuse services to Floridians who cannot afford the cost of their care. They report that they have difficulty obtaining insurance coverage that recognizes the type of services they provide and the risks to which they are exposed.[10]

Proponents suggest that a group program or self-insurance pool, specifically designed for the homogeneous group that comprises the Councils' membership, will enhance the availability of insurance for its members. The following types of insurance would be included in a pool:

Property Insurance — Florida presents unique problems in obtaining property insurance due to coastal wind and flooding exposure.

Automobile Insurance — Some insurance programs for behavioral health care agencies do not include automobile coverage, requiring FCCMH/FCBH members to obtain separate automobile insurance.

General Liability and Professional Liability —There are only four insurance companies that write liability policies for mental health and substance abuse agencies. Because of the size of market,

[10] FCBH proposal "Community Mental Health and Substance Abuse Provider Self-Insurance Fund" on file with the Insurance Committee.

underwriting is very stringent. One loss can result in the escalation of premiums and the imposition of unattractive "Claims Made" and "Retro Date" restrictions.

Workers' Compensation —Florida is not considered an attractive state to write workers' compensation policies. This has led to the lack of carriers willing to consider coverage for behavioral health agencies. An adverse loss history can lead to surcharges and higher premiums.

According to the FCCMH, 30-50 members are expected to participate in the self-insurance fund.[11]

The Council states that "along with other health care providers in Florida, mental health and substance abuse providers have seen rapid and sizable increases in their liability insurance premiums. This is especially true for agencies that operate inpatient emergency behavioral health care facilities such as crisis stabilization units. The average cost of liability insurance for a community mental provider was $238,847 in FY 2002–2003. The average cost in FY 2003-2004 was $355,715, an increase of 49%. But, for some providers, *the increase in premiums was 150% or more*."

As part of their proposal, the Council cites statutory precedent for creating group self-insurance programs. County governments and local municipalities are authorized to establish self-insurance programs so they can reduce costs and obtain less costly insurance through their pooled purchasing power and the ability to spread risk over multiple entities. Also, the Florida Independent Colleges and Universities Risk Management Association (FICURMA) was authorized by the Florida Legislature through section 624.4623 to establish a self-insurance fund. This group of private, non-governmental organizations has established a mechanism for members to obtain lower cost insurance and experience predictable future premium costs.

The language of HB 881 is modeled after the existing statutory authorization for local governments and private colleges and universities and, in fact, is mostly identical. However, section 624.4623 relating to the formation of self-insurance funds by independent colleges and universities contains a provision which is not included in HB 881. Pursuant to s. 624.4623 only those educational institutions accredited by the Commission on Colleges of the Southern Association of Colleges and Schools or accredited schools chartered by the State of Florida are eligible for the exemptions.

According to a representative of the Florida Independent Colleges and Universities Risk Management Association the prerequisite for accreditation requires that their members submit to the rigorous programmatic and financial review of this federally sanctioned accrediting agency. This outside review ensures that their pooled members are financially stable and have the appropriate resources to conduct their operations. The Federal government relies on this accreditation status for participation in all federally sponsored programs such as student financial aid, research contracts and other types of grants. Also, the colleges and universities rely on this accreditation status to be the primary test of an institution's financial strength.[12]

Among the financial and resource requirements necessary for good standing and membership are the following statements from the accrediting standards manual:

3.10 Financial and Physical Resources

1) The institution's recent financial history demonstrates financial stability.

2) The institution provides financial statements and related documents, including multiple measures for determining financial health as requested by the Commission, which accurately and appropriately represent the total operation of the institution.

3) The institution audits financial aid programs as required by federal and state regulations.

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[11] Id.

[12] Email from Ben Donatelli, Collaborative Ventures, Independent Colleges and Universities of Florida, March 19, 2005, on file with the Insurance Committee.

4) The institution exercises appropriate control over all its financial and physical resources.

5) The institution maintains financial control over externally funded or sponsored research and programs.

6) The institution takes reasonable steps to provide a healthy, safe, and secure environment for all members of the campus community.

7) The institution operates and maintains physical facilities, both on and off campus, that are adequate to serve the needs of the institution's educational programs, support services, and other mission-related activities

Regulatory Issues

In Florida, regulation of the insurance industry is shared by the Department of Financial Services (DFS) and the Office of Insurance Regulation (OIR or Office). The state's Chief Financial Officer (CFO) heads DFS while the head of OIR is the Governor and Cabinet members sitting as the Financial Services Commission. Generally, OIR is responsible for granting a certificate of authority or license to an insurer; a domestic insurer, i.e., an insurer based in Florida, must possess a certificate of authority in order to conduct business in Florida. Similarly, many insurers are required by law to seek OIR approval for their rates, or the prices they charge for coverage, and approval of the insurance forms they use for issuing policies. The Office of Insurance Regulation investigates allegations of fraud against insurers and administers state laws governing the financial reserve requirements imposed on insurers.

In HB 881 as originally filed, OIR was initially concerned that the authorization to create this self-insurance fund effectively removes any and all solvency and rate regulation oversight that is exercised by OIR in order to protect Florida's insurance consumers. According to OIR, the lack of regulatory oversight coupled with the significant risk this newly created self insurance would assume would have led to the formation of an inadequate financial framework to pay claims. They also opined that the inability to pay claims meant that injured employees otherwise eligible for workers compensation benefits may not have had medical and lost wage expense paid; that damaged property may have gone unrepaired; and that fund participants could have been drawn into costly litigation to personally defend against a liability claim.[13] In the Insurance Committee the bill was amended to add subsection (3) to s.626.4624, F.S which provides a transition time of 5 years for a self-insurance fund to comply with the same regulatory requirements of other commercial and group self-insurance funds, as well as to provide certain financial information to OIR.

Regarding the bill's creation of s. 624.4624(2), F.S., if the self insurance fund fails to comply, with the provisions of the entire section, the fund defaults to regulation under s.624.4621, F.S., -- regulation pertaining to group self-insurance funds writing only workers compensation insurance coverage. The office notes that the new section is silent with respect to a default regulation for the property/casualty and surety coverage being issued by the funds. In any type of forensic handling of a self-insurance fund in default, OIR opines that it could be difficult to determine the proper allocation of reserves that should have been associated with the multiple lines of coverage provided by the fund.

Sovereign Immunity

Background

Sovereign immunity is an ancient doctrine firmly anchored in common law which insulates the state and any governmental officers, employees, or agents acting on behalf of the state, from a lawsuit. As explained by Justice Holmes, "a sovereign is exempt from suit, not because of any formal conception or obsolete theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends." Although the extent of immunity has been considerably eroded by both federal

[13] Concerns expressed are contained in OIR's bill analysis on HB 881, on file with the Insurance Committee.

and state legislation, it is still retained under a social policy of protecting the state from burdensome interference with the performance of its governmental functions and excessive encroachments on the public treasury. The immunity is absolute and unqualified. However, Article X, Section 13, of the State Constitution permits the Legislature to waive sovereign immunity by general law.

The Tort Claims Act, s. 768.28, F.S., enacts the state's waiver of sovereign immunity. Immunity is waived only to the extent that the state or any of its agencies or subdivisions would be liable if a private person would be liable to a claimant. Further, liability does not include punitive damages, interest accrued, nor claims in excess of $100,000 per person, or $200,000 per incident. Employees, constitutional officers, and agents of the state and its subdivisions are immune from personal liability unless they act in bad faith, with malicious purpose, or in a grossly negligent manner. Any judgment above the cap must be sought from the Legislature through a claims bill.

The state and its agencies and subdivisions are authorized to be self-insured, enter into risk management programs, or purchase liability insurance for whatever coverage they choose. For those state executive agencies participating in risk management programs administered by the Department of Financial Services, agency premiums are calculated on the basis of the agency's loss experience. For those choosing to purchase insurance, sovereign immunity may be waived to the extent of the insurance coverage. Although all claims against state agencies or subdivisions in excess of the sovereign immunity cap must be approved by the Legislature in the form of a claims bill, payment of claims against counties, municipalities, hospital districts, or other political subdivisions of the state is almost always directed toward the local governmental entity rather than state general revenue.

Agents of the state are generally covered by the state's sovereign immunity, and may include persons or entities, not permanently employed by the state, who enter into contracts with the state. To be considered an agent, rather than an independent contractor, a certain degree of control or supervision must be exerted by the governmental entity over the activities the agent undertakes on the entity's behalf. The resolution of whether an individual is an agent of the government is a mixed question of law and fact. To invoke sovereign immunity, the agency relationship must not only be expressed contractually, but must be established factually in the actual execution of the contract.

In the area of health and family services, entities which contract with the state and seek to be agents pursuant to s. 768.28, F.S., are immune pursuant to three different statutory approaches.

General Statutory Provisions

First, as previously indicated, s. 768.28 (9), F. S., specifies that no officer, employee or agent of the state shall be personally liable in tort unless the employee acted outside the scope of his or her employment or in bad faith. Therefore, under this general provision a specific provider of health and family services who functioned legally as an agent could be protected from lawsuit.

Specific Statutory Definitions

Second, within the definition of "officer, employee or agent", specific providers of health care services are designated as agents, thereby immunizing these entities. Pursuant to s. 768.28 (9) (b), F.S., members of the Florida Health Services Corps who provide uncompensated care to medically indigent persons referred by the Department of Health are explicitly defined to be officers, employees or agents of the state. Likewise, health care provider serving clients pursuant to s. 766.1115, F.S., are also considered to be officers, employees or agents.

Section 766.1115, F.S., originally created in 1992 and reenacted in 1997, provides sovereign immunity to private-sector health care providers who contract as agents of governmental entities for the purpose of providing free health care services to low-income clients of the entities. Unlike the general provisions of s. 768.28, F.S., this section establishes the conditions that must be in the contract for the health care provider to be considered an agent of the governmental contractor. The contract must provide: 1) a right of dismissal of

the provider by the governmental contractor; 2) a governmental contractor's right to access to patient records; 3) that adverse incidents and treatment outcomes be reported by the provider; 4) patient selection and referral be made solely by the governmental contractor, and that the provider accept all referred patients; 5) that the patient be referred within 48 hours after emergency care is provided; 6) that patient care be subject to the governmental contractor approval; 7) that the provider be subject to the supervision and inspection by the governmental contractor.

The statute also requires the governmental contractor to provide written notice to all clients that the provider is an agent of the contractor and that the exclusive remedy for injury is under the sovereign immunity statute. Moreover, this section requires the governmental contractor to establish a quality assurance program to monitor contractual health services under this statute.

Specific Statutory Provisions

The third approach in s. 768.28, F.S., to immunize providers of health and family services is found in subsections (10) and (11). Here, specific entities are granted agency status. These include: 1) health care providers who contract with the Department of Corrections to provide health care to inmates; 2) regional poison control centers coordinated and supervised under the Division of Children's Medical Services of the Department of Health and, 3) providers of services to children and families in need of services under contract with the Department of Juvenile Justice. For these entities, agency status is predicated on three conditions. One, providers must contractually agree to act as agents. Two, providers must act within the scope of and pursuant to guidelines established in the contract or by rule. Three, providers must indemnify the state for any liabilities incurred up to the limits set forth in s. 768.28, F.S.
In addition to the three aforementioned statutory approaches taken in s. 768.28, F.S., is an option found in s. 381.0056 (10), F.S. Passed by the 1999 Legislature, this provision specifies that any entity providing school health services under a local school health services plan and as part of a public-private partnership be considered an instrumentality of the state for purposes of sovereign immunity. The entity must act within the scope of and pursuant to guidelines established in the contract or by rule of the Department of Health, and the entity must obtain general liability insurance coverage. This provision also states that under no circumstances shall the state or the department be responsible for payment of any claims or defense costs for claims brought against the entity or its subcontractor for services performed.

Regardless of which approach is taken to immunize entities by conveying agency status, the fundamental issue remains whether an agency relationship actually exists. Accordingly, to better understand this question, it is necessary to review more thoroughly the salient features of what constitutes agency relationships.

Law Relating to Agency Status

The Florida Supreme Court has held that a person or entity may share in governmental immunity only when performing activities within the scope of a true agency relationship with a sovereign. Stated another way, an entity or business acting as an independent contractor of the government, and not as a true agent, logically cannot share in the full panorama of the government's immunity (This is not to say that an independent contractor cannot also be an agent, as will be discussed later).

Under Florida law, the essential elements of an agency relationship are (1) acknowledgment by the principal that the agent will act for it, (2) the agent's acceptance of the undertaking, and (3) control by the principal over the actions of the agent. Of these, the issue of control is central to the determination of agency. In a true agency relationship the principal must control, the means used to achieve the outcome, and not just the outcome itself. Central to this determination are questions as to who has the right to direct what shall be done, and when and how it shall be done. Control over the person as well as the performance of the work to the extent of prescribing the manner in which the work shall be executed and to the methods and details by which the desired results is to be accomplished, is also a key feature in establishing an agency relationship.

In the specific area of health and family services the courts have provided guidance as to the factors that must be present to ensure immunity for providers. In Stoll v. Noel, 694 So.2d 701 (Fla. 1997) the issue before the

Florida Supreme Court was whether immunity pursuant to s. 768.28, F.S., should be granted to physician consultants who contracted with the Division of Children's Medical Services (CMS) of the then Department of Health and Rehabilitative Services (HRS). The Supreme Court held that the physicians were agents of the state and thus were entitled to statutory immunity.

In reaching its decision the Court focused primarily on the degree of control retained or exercised by CMS. The Court found that:

1) CMS required each consultant as a condition of participating in the CMS program, to agree to abide by the terms published in its HRS Manual and CMS Consultant's Guide which contained CMS policies and rules governing its relationship with the consultants.
2) The Consultant's Guide stated that all services provided to Children's Medical Services' patients be authorized in advance by the clinical medical director.
3) The language of the HRS Manual ascribed to CMS responsibility to supervise and direct the medical care of all CMS patients and supervisory authority over all personnel.
4) The manual also granted to the CMS medical director absolute authority over payment for treatment proposed by consultants.
5) The HRS Manual and the Consultant's Guide demonstrate that CMS has final authority over all care and treatment provided to CMS patients, and it could have referred to allow a physician consultant's recommended course of treatment of any CMS patient for either medical or budgetary reasons.

Also, the court noted that its conclusion was buttressed by HRS's acknowledgment that the manual created an agency relationship between CMS and its physician consultants, and despite its potential liability in the case, by HRS acknowledgment of full financial responsibility for the physicians' actions.

In 1999, the Fourth District Court of Appeal decided a case which provides additional insight into how the courts will look at this issue. In Theodore ex rel. Theodore v. Graham, 733 So.2d 538 (Fla. App. 4 Dist. 1999) the issue was whether Dr. Annie Dawn-Marie Graham was entitled to summary judgment based on her affirmative defense of sovereign immunity. The case arose out of an incident involving a patient at the Regional Perinatal Intensive Care Center (RPICC) who was treated by Dr. Graham, the obstetrical director of the center. The trial court granted Graham's motion for summary judgment, ruling that the case was controlled by Stoll v. Noel. In so doing, the court viewed the record in the light most favorable to the plaintiffs and ruled that as a matter of law the plaintiff was not entitled to relief.

The District Court reversed and remanded. The Court found that the employment contract did not reserve to the government that extensive control over the patient's course of treatment which justified the result in Stoll. Central to the Court's findings were the following:

1) Determination of medical eligibility and final medical decision for admission of a patient was made by Graham;
2) Provisions in Graham's contract with HRS indicated an independent contractor status including assumption of liability for negligence and indemnification of HRS for damages arising out of her own negligent acts in the course of the operation of the contract;
3) An attachment to her contract which required Graham to develop a protocol establishing transfer procedures for patients with high risk needs;
4) Unlike the situation in Stoll, no provision incorporated in Graham's contract gave the government the right to control Graham's decision regarding patient treatment;
5) Testimony by Graham that her contract with HRS placed no restriction on the exercise of her professional judgment in treating patients. The department never attempted to dictate policies or procedures regarding how the government wanted her to diagnose and handle patients.

Given these findings the Court held that the issue of whether Graham was an agent of the state entitled to the s. 768.28 (9) (a) defense of sovereign immunity was a question of fact that could not be resolved by summary judgment. Hence, the case was remanded to the trial court for further litigation.

Background on Provision of Mental Health Services and Treatment and Prevention of Substance Abuse

The Department of Children and Families (DCF) contracts with community-based substance abuse and mental health treatment providers to deliver services on behalf of the state to individuals who have a mental health or substance abuse disorder. These agencies deliver a wide range of services to local communities, from prevention and outpatient therapy to critical crisis intervention and detoxification services.

As of Fiscal Year 2004-2005, the department maintains contracts with 249 community mental health provider agencies and 159 substance abuse provider agencies. Of 249 mental health agencies, 55 provide mental health crisis services. Of the159 contracted substance abuse provider agencies, 32 provide substance abuse detoxification services. In the first half of fiscal year 2004-05, these agencies provided mental health crisis intervention or detox services to 35,216 individuals.[14]

Current DCF contract language clearly specifies that a provider is an independent contractor not an agent. The specific relevant section reads:

> To act in the capacity of an independent contractor and not as an officer, employee of the State of Florida, except where the provider is a state agency. Neither the provider nor its agents, employees, subcontractors or assignees shall represent to others that it has the authority to bind the department unless specifically authorized in writing to do so . . . To take such actions as may be necessary to ensure that each subcontractor of the provider will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the State of Florida.[15]

Under Florida law, receiving facilities are required to examine and provide treatment to everyone— regardless of their diagnosis or their ability to pay. According to FCCMH, approximately 98% of persons served by these facilities are low income, uninsured individuals or Medicaid eligible. Virtually all funding for receiving facilities comes from local, state and federal government sources.

According to the Council, the cost of medical malpractice liability insurance is limiting the ability of publicly supported community mental health and substance abuse agencies to provide critical treatment and intervention services that are depended upon by law enforcement, local communities and state agencies. The Council states that medical malpractice insurance rates for community mental health and substance abuse agencies have increased 105% over the past three years, approximately 35% per year. In some cases, 5% or more of a facility's operating budget is used to pay for liability insurance— resources that could otherwise be used for treatment.

The average cost of liability insurance for a community behavioral health provider was $238,847 in FY 2002–03. The average yearly cost in FY 2003-04 was $355,715, an increase of 49%. As an example of the impact on treatment capacity, a community mental health provider could have provided an additional 1,457 bed days of crisis stabilization care in lieu of paying for liability insurance during FY 2003-2004. The following chart provided by FCCMH shows examples of the escalation of liability insurance premiums (which includes medical malpractice, officers and directors insurance and other liability insurance) for a sample of behavioral health care providers

[14] Department of Children and Families bill analysis on HB 881, on file with the Insurance Committee.
[15] Id.

Facility	FY 2002-03 Premiums	FY 2003-04 Premiums	% Increase
ACT Corporation, Daytona Beach	$391,000	$425,000	8.7%
Lakeview Center, Pensacola	$555,301	$793,063	42.8%
Personal Enrichment through Mental Health Services, Pinellas Park	$72,315	$225,662	212.1%
Mental Health Care, Tampa	$184,288	$489,007	165.3%
Meridian Behavioral Health, Gainesville	$91,426	$113,076	23.7%
Apalachee Center, Tallahassee	$95,630	$247,239	158.5%
Bayview Center, North Miami	$74,000	$94,000	27.0%
Circles of Care, Melbourne	$463,972	$512,060	10.4%
Citrus Health Network, Hialeah	$221,691	$302,331	36.4%

Report by the Department of Children and Families on the Experience of Public Receiving Facilities in Securing and Maintaining Medical Malpractice Insurance

The 2004 Florida Legislature mandated that the Department of Children and Families develop a report which reviewed the experience of public receiving facilities as defined in section 394.455, Florida Statutes, in securing and maintaining medical malpractice insurance. The review was to include the current cost of insurance and the rate of increase or decrease in these costs over the past three years and the experience of these facilities with lawsuits and associated awards. The department was directed to investigate whether these facilities were experiencing problems with malpractice insurance and the impact such problems have on service delivery. Recommendations regarding this issue were also required to be included in the report. The department delivered the report to the Governor and the Senate and House Appropriations committees by December 31, 2004. The following is an excerpt from the DCF report.[16]

Public receiving facilities, as defined in section 394.455, Florida Statutes, include crisis stabilization units, children's crisis stabilization units, and hospital inpatient units that have a contract with the Department. These facilities receive state funds to provide short-term intensive acute mental health services to voluntary and involuntary persons.

METHODOLOGY USED TO ESTIMATE MEDICAL MALPRACTICE COST

Providers were asked to provide the annual cost of the public receiving facility's medical malpractice insurance.[17] Only one agency of the 26 reporting agencies provided this information.

[16] Florida DCF report: The Experience of Public Receiving Facilities in Securing and Maintaining Medical Malpractice Insurance, December 31, 2004, on file with the Insurance Committee.

[17] Medical malpractice, as defined by DCF in this report, "means injudicious treatment of a patient, professionally and in respect to the particular diagnosis, resulting in injury, unnecessary suffering, or death to the patient and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rule or principles, neglect or a malicious or criminal intent."

If the annual cost of the medical malpractice insurance for the public receiving facility was not available the provider provided budgetary information to serve as an approximation of insurance cost attributable to the public receiving facility.

Based on survey findings the percentage of public receiving facility budget compared to total agency budget as of FY 2004 - 2005 is 14.59%. This percentage has remained consistent over the past four years.

It was determined that the median total insurance cost increased 72.5% over the four years, from $104,249 in FY 2001 - 2002 to $179,845 in FY 2004 - 2005. The median total insurance cost peaked at a high of $223,457 in FY 2003 - 2004.

Using the 14.59% approximation above, the median cost of insurance attributable to the public receiving facilities increased from $15,210 in FY 2001 - 2002 to $26,239 in FY 2004 - 2005. The median insurance cost attributable to public receiving facilities peaked at a high of $32,602 in FY 2003 - 2004.

This cost may be an underestimate, given that public mental health receiving facilities serve children and adults who are experiencing acute symptoms of emotional disturbances and mental illnesses. These services are provided in a licensed inpatient setting staffed by medical personnel.

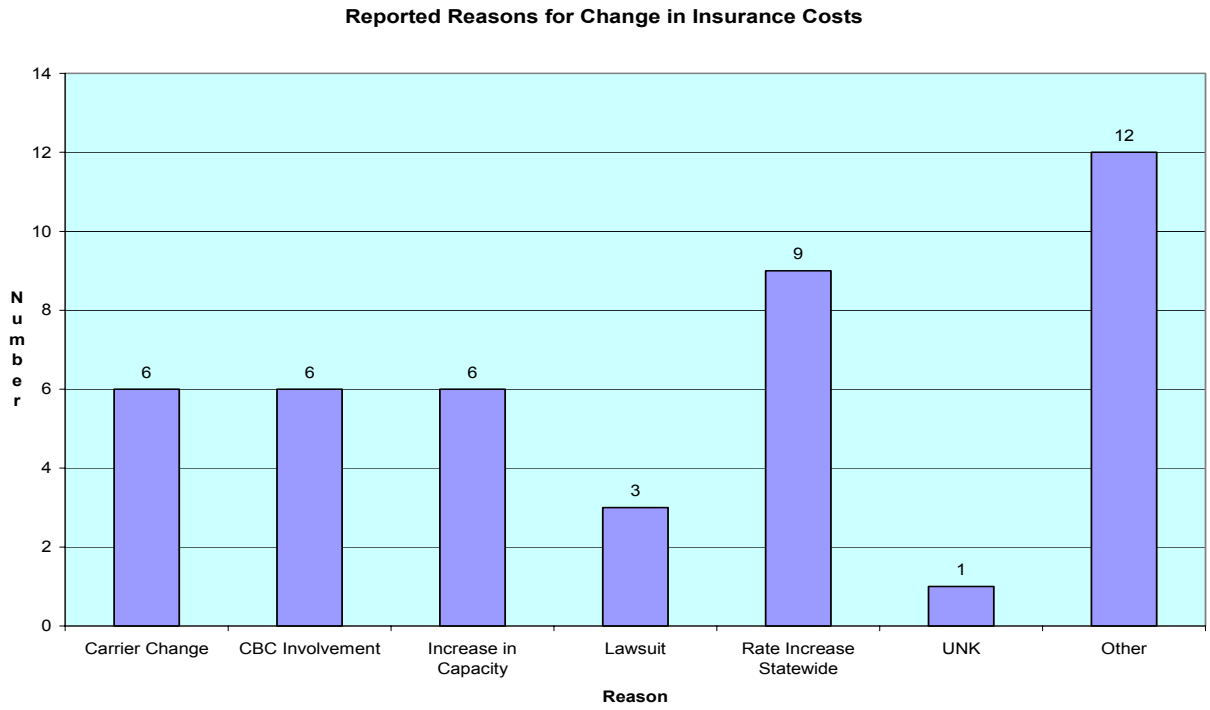
It could not be determined what percent of the total public receiving facility insurance cost was specifically related to medical malpractice insurance costs since most agencies were unable to specify this cost.

FINDINGS

The findings include overall insurance costs, litigation, and system impact as follows:

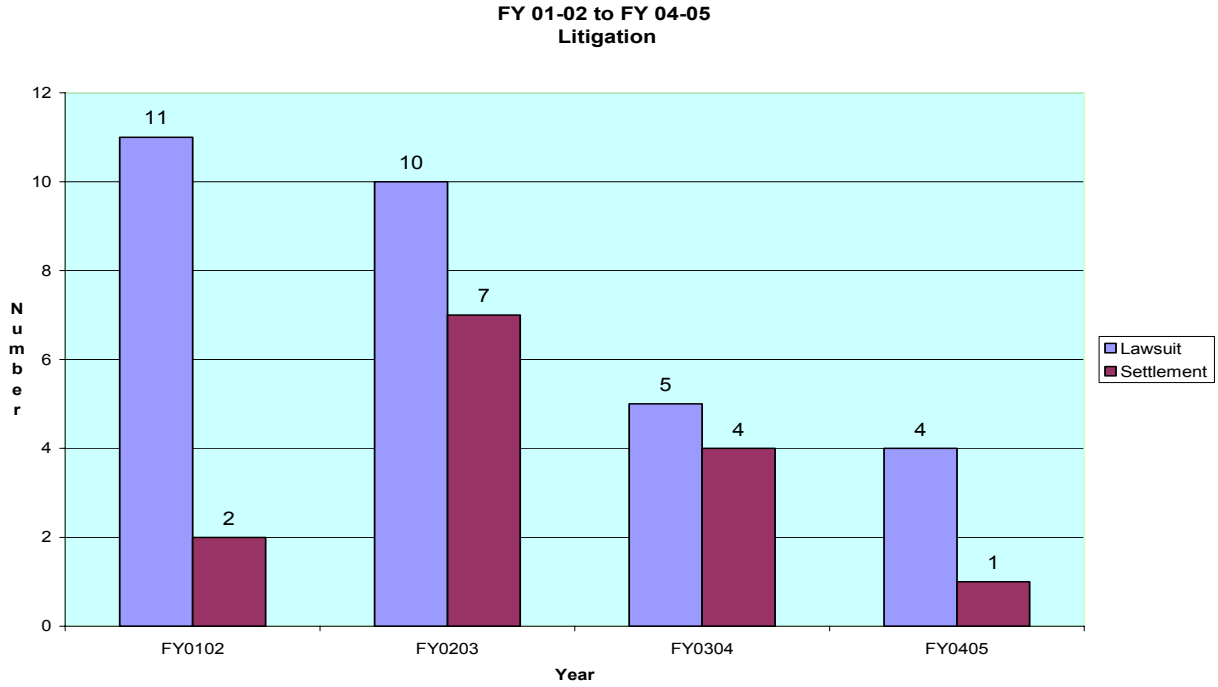
Overall Agency Insurance Costs

- Most reporting providers did not have cost data specific to medical malpractice costs, they reported total insurance cost.
- The median total insurance cost rose 72.5% during the four years, from a low of $104,249 in FY 2001 - 2002 to $179,845 in FY 2004 - 2005. The median total insurance cost peaked to a high of $223,457 in FY 2003 - 2004.
- The median cost of insurance for public receiving facilities rose by 72.5% during the past four years, from $15,210 in FY 2001 - 2002 to $26,239 in FY 2004 - 2005. The median insurance cost for public receiving facilities peaked to a high of $32,602 in FY 2003 - 2004. These costs were estimated based on the percentage of the public receiving facility budget to overall agency budget, and may be an underestimate of insurance costs related to public receiving facilities.
- The average cost of insurance for reporting providers is $236,821 for this fiscal year. This represents a 67.59% increase from an average cost of $141,309 in FY 2002 - 2002. The average, minimum and maximum total cost of insurance of reporting agencies from FY 2001 - 2002 to FY 2004 - 2005 is displayed in Appendix F.
- The predominant factor associated with change in insurance costs for all providers was rate increases by insurance carriers. The reported reasons for change in insurance costs are displayed below.



Litigation

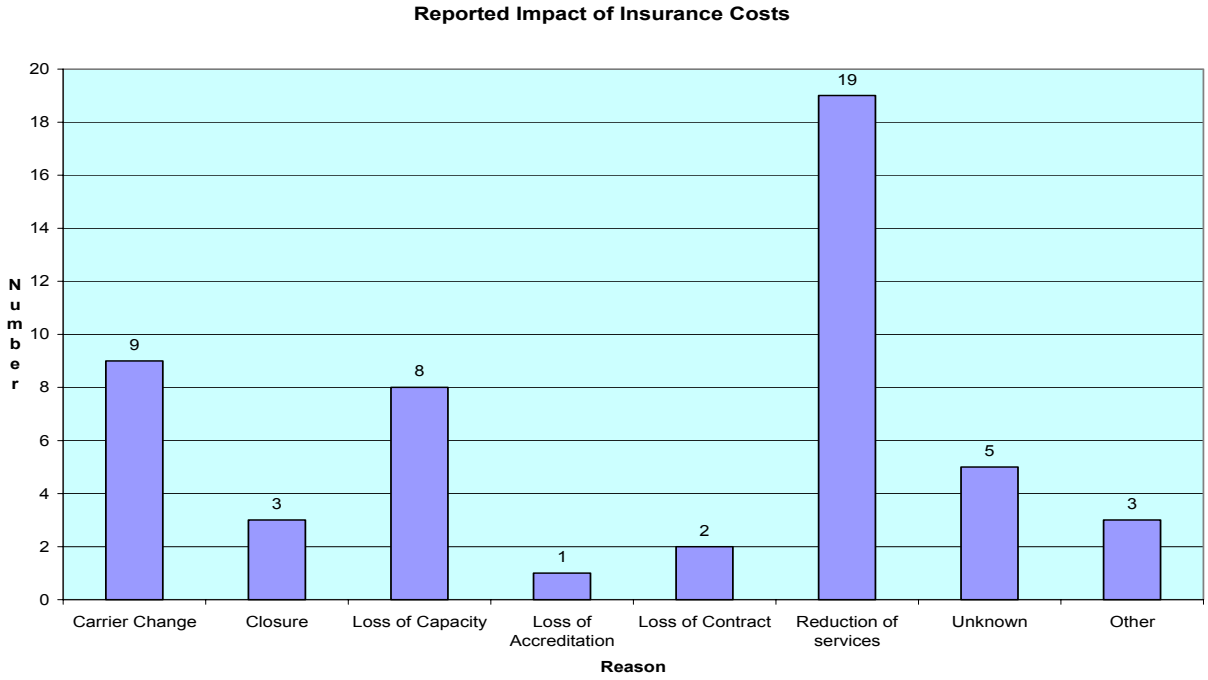
- The reporting agencies provided information about their lawsuits and settlement agreement activity.
- The number of lawsuits has declined from 11 in FY 2001 - 2002 to four in FY 2004 - 2005. The number of settlement agreements generally declined over the same time frame, from a peak of seven settlement agreements in FY 2002 - 2003 to a current low of one settlement agreement in FY 2004 - 2005.



- Rate increases by insurance carriers may have followed litigation activity which increased an average of 15 open cases in FY 2002 - 2002 and FY 2002 - 2003 compared to an average of six open cases during FY 2003 - 2004 and FY 2004 - 2005.

System Impact

- Nineteen of the responses indicated a potential for reductions in agency-wide services as a result of increased insurance costs. Eight of the responses indicated potential loss of agency-wide capacity in addition to the reduction in services. Reported impact of insurance costs:



- The reporting agency's acute care budgets have increased by 23.01% from $2,564,742 in FY 2001 - 2002 to $3,155,014 in FY 2004 - 2005.

- In FY 01-02 the state contracted for 254,294 units (696.7 beds) in public receiving facilities. In contrast, during FY 04-05 the state has contracts for 210,198 units (575.9 beds) in public receiving facilities. This represents a decline of 17.3%. However, the survey responses did not provide sufficient information to attribute these decreases solely to the increased cost of medical malpractice insurance.

RECOMMENDATION

The Department will continue to study this issue to establish more definitive trends in the cost of medical malpractice insurance, the prevalence of lawsuits and awards, and the associated impact on service delivery at public receiving facilities.

Proposed Changes Regarding Sovereign Immunity
The bill designates certain substance abuse treatment and mental health service providers as agents of the state for the purposes of the sovereign immunity statute. It grants immunity pursuant to contractual arrangements between providers and the Department of Children and Families (DCF). However this immunity status is not bestowed on services provided to a self-paying or insured patient. The bill also states that the contract must provide for the indemnification of the state by the agent for any liabilities incurred up to the limits set out in law and that a person who provides contracted services to DCF is not an employee or agent of the state for purposes of workers' compensation.

C. SECTION DIRECTORY:

Section 1 creates s. 624.4624, F.S., relating to nonprofit community mental health and substance abuse providers self-insurance fund.

Section 2 amends s. 768.28, F.S., relating to waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitation; exclusions; indemnification; and risk management program.

Section 3 provides an effective date of July 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Section 1 of the bill exempts providers who form a self-insurance fund from paying the premium tax on their insurance policies which will result in an indeterminate decrease in revenues to the state. This decrease should only occur after the self-insurance fund has been in existence for five years.

2. Expenditures:

Allowing providers who contract with DCF to become agents of the state will impact state resources in that the state will have to defend itself and manage cases. The Department of Financial Services provided the following statement:

> NOTE: As we do not know the number of entities involved, nor do we have the claims history for these non-profit vendors, we are unable to provide actual or estimated expenditures from the State Risk Management Trust Fund. Please see comments section.[18]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

[18] DFS bill analysis on HB 881, on file with the Insurance Committee.

To the extent that providers reduce their costs for liability insurance and from legal immunity, the offering of services, with the attendant emotional and financial benefits, may increase for families. To the extent that injured patients are not able to recover fully for their injuries then more families may be dependent on Medicaid or other governmental assistance programs.

D. FISCAL COMMENTS:

The following fiscal comments were contained in the DFS bill analysis:

If this bill becomes law, Risk Management will likely have to extend general liability insurance coverage to non-profit community mental health services providers or substance abuse providers as agents of the state. Risk Management would pay claims for bodily injury, death, and property damage resulting from negligence by the non-profit organization in providing these services. However, this bill requires the non-profit organization ("non-profit") to indemnify or reimburse Risk Management "for any liabilities incurred" up to the limits of our coverage ($100K per person, $200K per occurrence.) These are the monetary limits specified in the state's waiver of sovereign immunity.

Depending on the interpretation of this bill by DCF, which will be reflected in the contracts between DCF and the non-profit, there may not be any fiscal impact on Risk Management. By making these non-profits agents of the state, they are entitled to certain protections afforded by sovereign immunity. Employees of the non-profit cannot be sued individually and the monetary liability limit of the non-profit is capped at $100K/$200K. The non-profit will still have to maintain worker's compensation coverage and DCF may elect to require them to maintain general liability coverage. If so, the general liability carrier could defend the non-profit and be responsible for up to the limits of sovereign immunity, $100K/$200K in damages, plus defense costs, and there would be no fiscal impact on Risk Management.

Assuming Risk Management provides general liability coverage for these agents, for most claims, there may be no fiscal impact on the Risk Management fund if these claims do not exceed the $100K/$200K monetary limits and even if they do, these are the maximum amounts that Risk Management can pay. If a claimant obtains a judgment in excess of these limits, he/she can seek the excess amount through a legislative claims bill, which would be paid by DCF. A study of claims reported in the last 5 years shows that no general liability claim against the substance abuse program or the mental health program has resulted in a total payout of over $100K/$200K. However, we do not have records showing what the non-profit might have paid for claims during this period for services rendered to DCF clients.

There are two situations where Risk Management may have to pay money not recoverable from the non-profit. One situation is where we pay defense attorney fees and costs to defend a lawsuit and the claimant obtains a judgment or the case is settled for $100K/$200K. This bill, as written, does not have a provision for payment or indemnification above $100K/$200K to reimburse Risk Management for defense attorney fees and costs above these limits. We recommend language be amended to add that attorney fees and costs be also indemnified in full in addition to damages up to $100K/$200K. The other situation involves claims that go into litigation requiring Risk Management to expend money to defend the non-profit (defense attorney fees and costs.) The non-profit is required to indemnify Risk Management for "any liabilities incurred" but it is not clear if this includes just damages to pay the settlement or judgment or includes defense attorney fees and costs. Therefore, it is possible that Risk Management could expend money for defense costs and the non-profit refuse to reimburse these costs, as they are not "damages."

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to take an action requiring the expenditure of funds; does not reduce the authority that counties or municipalities have to raise revenue in the aggregate, and does not reduce the percentage of state tax shared with counties or municipalities.

2. Other:

B. RULE-MAKING AUTHORITY:

This bill does not delegate rule-making authority to any administrative authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Drafting Issue

In the past when proposals have been discussed about making private entities agents of the state concerns have been raised that in addition to the damages the state will pay up to the statutory limits (which this bill requires the providers to reimburse) the state also incurs expenses relating to defense and case management costs. An amendment could be drafted which requires that those costs would also be reimbursed to the state and which provides reasonable enforcement of same.

Comments by OIR

The Office of Insurance Regulation provided the following comments regarding the bill when the bill did not contain the 5 year transition period where the funds would have to comply with a full panoply of regulatory requirements. However, their comments are still relevant to the fund's operation after the first five years of existence:

Technical Review – The construction of newly created 624.4624:

The newly created self-insurance fund (SIF), as drafted in this legislation, was not drafted to expand the definition of "commercial" self-insurance fund (otherwise defined at 624.462). Thus, the provisions of 624.460 – 624.488 ("Commercial Self Insurance Funds") would not apply to this newly created SIF.

And, the newly created SIF is, at subsection (2) of this billl, exempt from 624.4621 for purposes of definition and regulation as group self-insurance fund formed to provide workers compensation coverage.

Thus, by construction of the statute, the newly created SIF appears regulated only by the specific provisions within its newly created statute, s. 624.4624. That construction:

- Exempts the fund from any form of solvency requirement;
- Does not provide the OIR with authority to protect member participants against inadequate rates and premium collection;
- Is constructed to exempt the fund from requirements otherwise applicable to self-insurance funds – either those formed to provide self-insurance for workers compensation insurance or those formed for sharing property and casualty and surety risk; and,
- Creates an ambiguity related to Guaranty Fund Protection – i.e.,:
    - For risks associated with property/casualty and surety, it is not clear if the newly created SIF would qualify for FIGA protection, because at s. 624.462(5) a commercial self-insurance fund is required to participate in FIGA. This newly created SIF is not bound by the provisions of 624.462;
    - For risks associated with workers compensation, s. 631.905(5)[19] the FIGA workers

[19] 631.904 Definitions.--As used in this part, the term:
(5) "Insurer" means an insurance carrier or self-insurance fund authorized to insure under chapter 440. For purposes of this act, "insurer" does not include a qualified local government self-insurance fund, as defined in s. 624.4622, or an individual self-insurer as defined in s. 440.385.

compensation account may cover this SIF, because the definition of covered entities specifically excludes only local government SIFs organized under s. 624.4622 (group self-insurance funds formed specifically for providing workers compensation benefits);

With respect to the occurrence of a deficit, a significant difference between the SIFs already permitted in statute and that proposed in this bill is that local government SIFs created at 624.4622 could generate additional revenues with the exercise of local government taxing authority. Independent educational SIFs created at 624.4623, could raise revenues through additional tuition and fees. In contrast, nonprofit community mental health and substance abuse providers have no associated source of additional revenue generation.

Subsection (1)
In describing the risk being assumed by the newly created SIF the term "securing the payment of benefits under Chapter 440" may mean the SIF intends to provide workers compensation coverage to its participants.

However, at subsection (2) the legislation specifically exempts the newly created SIF from the requirements that apply to group self-insurance funds at s. 624.4621, designed for SIFs that provide workers compensation insurance to member participants.

Subsection (1)(a) -- requires the fund to have "annual normal premiums in excess of $5 million"
The self-contained nature of the newly created statute implies there would be no oversight of policy form or rate approval. Member participants would not benefit from the protections of form and rate approval that assure rates are not excessive, inadequate, or non-discriminatory and that contracts issued by the fund provide reasonable benefits for the risks being assumed by the fund.

Subsection (1)(b)
Requires the fund, as determined by a qualified actuary, to maintain a program of excess insurance coverage. The actuary is also to provide a reserve evaluation – but not an actuarial opinion -- in light of the need to protect the financial stability of the fund.

Subsection (1)(b) does not require rate development by a qualified actuary and does not require the fund to maintain reserves sufficient to meet the cost of risks associated with the coverage the fund will provide.

Comments by Proponents

The Florida Council for Community Mental Health supports exemptions for establishing self-insurance funds for the following reasons:

1) Insurance policies for behavioral health care providers are generally written in "programs" designed for health care organizations. These include nursing homes, hospitals, clinics, blood banks and other health care organizations with related medical practice risks. While these programs serve a good purpose, they are not designed for the unique needs of community mental health and substance abuse agencies. They do not offer behavioral health providers the consistency and quality of coverage they need. Furthermore, many of these insurance programs are nationwide in scope and do not recognize the particular needs of community agencies in Florida.

2) By establishing a Group or Self-Insurance Pool, much greater stability can be provided to FCCMH/FCBH members for all lines of property, liability, automobile, workers' compensation, and directors and officers insurance. By using their group "buying power," members can obtain direct access to reinsurers who will cover their unique risks. But, on an individual basis, members are left to the decisions of a very few underwriters.

Continuation of footnote 20: (6) "Self-insurance fund" means a group self-insurance fund authorized under s. 624.4621, a commercial self-insurance fund writing workers' compensation insurance authorized under s. 624.462, or an assessable mutual insurer authorized under s. 628.6011. For purposes of this act, "self-insurance fund" does not include a qualified local government self-insurance fund, as defined in s. 624.4622, or an individual self-insurer as defined in s. 440.385.

3) The purchasing organization established by FCCMH/FCBH members would have the use of funds that are set aside to pay claims. Because larger claims tend to take months or years to settle, reserves are established for future payment and settlement. The self-insurance organization would benefit from the investment earnings from this fund. When "old years" close out, funds could be returned to the members in the form of dividends and used to credit future premiums.

4) The potential savings over time from a self-insurance program could reduce mental health and substance abuse providers' administrative costs, thereby preserving more dollars for treatment.

Regarding section 2 of the bill which makes providers who contract with the state for the provision of mental health and substance abuse services agents of the state and immune from liability, the Council states that:

1) Community mental health and substance abuse agencies are funded by public entities and operate in the public interest.

2) These programs operate under the provisions of Chapters 394 and 397, Florida Statutes, and are highly regulated under state administrative rule pursuant to the Florida Administrative Code, 65E and 65D series.

3) Because they act on behalf of the state, these community providers and their employees and agents should receive the benefit of immunity and/or liability limits for their publicly funded services.

4) Similar limits/immunity are granted to health care and other providers serving inmates of the state correctional system, community based providers who contract with the Department of Juvenile Justice to serve children or families in need of services or juvenile offenders, and eligible child welfare, lead agencies/community based providers as defined in s. 409.1671(1)(c), F.S.

Comments by Opponents

An opponent of both sections of the bill, the Academy of Florida Trial Lawyers assert that:

1) The vast majority of the clients of such agencies are Medicaid-eligible individuals. The private entities which will benefit from the immunity currently are liable for the injuries and damages they cause to these clients, but most of the financial burden of those damages will be shifted to the Medicaid program, as well as to Social Security and other public sources.

2) Mental health care and addiction therapy providers have a history of abuse inflicted upon their clients during their institutionalization, as well as severe injuries and deaths caused by the gross neglect of those charged with their safety and well-being. Court verdicts and settlements of meritorious claims have acted as the last form of deterrent to agencies whose carelessness will be immunized by this bill. The frequency of disabling injuries and deaths which otherwise would be the responsibility of the contracting agencies is certain to increase as the deterrent is eliminated by immunity, according to the bill's opponents.

3) The $100,000 limits provided by the exception to sovereign immunity is woefully insufficient to satisfy serious claims of disabling injuries and deaths, which all-too-often result from the negligence of those charged with the safety of the mentally ill and addicted who cannot during their institutionalization care for themselves. The limit was established decades ago and has not been raised to meet inflationary trends or to match the true value of valid claims.

4) The extension of sovereign immunity to these private agencies is not in keeping with the legal standards for immunizing governmental agents. The Department of Children and Families contracts out these services because the administrative burden of directly supervising and controlling such caregivers is substantial. The agencies promise to relieve Florida state governmental authorities of the need for direct supervision of the means used to achieve treatment goals.

5) The Florida Supreme Court has recognized that "[a] person or entity may share in governmental immunity only when performing activities within the scope of a true agency relationship with a sovereign," and that "[t]he existence of a true agency relationship depends on the degree of control exercised by the principal." Dorse v. Armstrong World Industries, Inc., 513 So.2d 1265, 1268 (Fla. 1987). The services provided by the agencies in question are professional services which are not so directly controlled by DCF as to render the providers agents of the State. Such acceptance of responsibility by these contracting providers carries with it a level of independence which normally precludes one from claiming status as an agent of state government."

6) The self-insurance provision of the bill presents its own set of problems. The Academy declares that while the contracting mental health and addiction facilities are supposed to indemnify the State for the $100,000 limits of liability which will be paid to those injured by their caretakers, the bill permits those facilities to participate in a self-insurance fund which lacks many of the protections of actual liability insurance. They argue that the State will be left to foot the bill for those claims which are not indemnified by the contracting agencies and/or those funds.

7) Those participating in such funds will not be required to establish reserves applicable to insurance companies. If the funds become insolvent, the safeguard of the Florida Insurance Guaranty Association will not be available to those with valid claims. The funds will not be subject to the regulatory control of the Department of Financial Services and will not be subject to the statutory remedies which serve to regulate the insurance industry.

NOTE: Comment # 7 by the Academy would no longer apply for the first five years of the funds existence. The bill was amended to require funds to comply for 5 years with the same regulations applicable to other funds.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 24, 2005 the Insurance Committee considered and adopted 3 amendments to the bill. As originally filed the bill required providers to be members in good standing with the Florida Council for Community Mental Health and The Florida Council for Behavioral Healthcare in order to qualify for the bill's self insurance fund provisions. An amendment was adopted to delete that specific reference and replace it with a more general classification. The second amendment provided a transition time for the formation of self-insurance funds; allowing regulatory oversight and requiring financial reporting. The final amendment restricted application of agency status to only those providers who treat publicly funded patients.

This staff analysis addresses the bill with these three amendments incorporated.